MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6341

06326

1. NAME OF DECEASED (Type or Print): Lola Florence Aliff

2. DATE OF DEATH: 6/15/61

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION: Anne Arundel County
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION): Brooklyn-25
5320 Brookwood Rd. A. A Co.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: An. Ar. Co.
C. CITY OR TOWN (If outside city limits, write RURAL and give township): X Brooklyn
D. STREET ADDRESS (If rural, give location): 5320 Brookwood Rd

5. SEX	6. COLOR or RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Year: Months / Days	If Under 24 Hours: Hours / Min.
Female	W	Wid	5/20/87	74		

10.A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Witt	Lucy Cox

15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		Family	Same

I CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary occlusion
DUE TO
(B) cardio-hypertensive vascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

420.1

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES ☐ NO ☐

22. I certify that (I) (this hospital) attended the deceased from 4/19 19 54 to 6/15 19 61 that (I) (we) last saw the deceased alive on 4/15 19 61 and that in (my) (our) opinion death occurred at 6:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE	23B. ADDRESS	23C. DATE SIGNED
Philip W. Keister M. D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	302 Patapsco Av	6-16-61

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	6/19/61	Loudon Pk.	Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS
JUN 19 '61	Arthur S. Krause	McCully Funeral Hms. 130 E. Fort Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Items 18-21 Film 290 7 13 [illegible]

1

FOR STATE HEALTH DEPT.

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2

2

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06327

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft. George C. Meade
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 22 Country Club Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GRACE — Middle: ELLEN — Last: ANDERSON

4. DATE OF DEATH: Month: June — Day: 27 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/30/14

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Smith

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): No

16. SOCIAL SECURITY NO.: [redacted]

17. INFORMANT — Address: Retired Major George S. Anderson (husband)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ingestion of meprobamate and alcohol — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

888.9

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Ingestion of meprobamate and alcohol

20c. TIME OF INJURY — Hour a.m. p.m. / Month, Day, Year: Unknown, 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Unknown

20f. (City or town) (County) (State): Unknown

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: 6/28/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7-1-61

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven

22d. LOCATION (City, town, or country) (State): Glen Burnie, Md

23. FUNERAL DIRECTOR — ADDRESS: Hopping & Wirtley, Glen Burnie

24a. REC'D BY REGISTRAR — DATE: JUL 3 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6343 — 06328

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 10yr., 1mo

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore. 21201-4
d. STREET ADDRESS: 629 Central Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	Farrow	Anderson	6	3	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	C		6-15-1894	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemical Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Prince Edw. Cy., Va.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: unknown John Frank Anderson
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: medical records. C&H.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory failure. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Dehydration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Infection — decubitus ulcers, Hypostatic pneum.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-7-, 1951 to 6-3-, 1961, that (I) (we) last saw the deceased alive on June 3 19 61, and that death occured at 9:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Enrique J. del Campo M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 6-3-61
22c. PHYSICIAN'S NAME (Type): Enrique J. del Campo
22d. ADDRESS: Crownsville State Hospital. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 7/61
23c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
23d. LOCATION (City, town or county) (State): A.A. County Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Milton E. Ebicken
ADDRESS: 1129 N. Caroline St.
25e. REC'D BY REGISTRAR DATE JUN 9 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1B (4)
15M 9/60

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6344

CERTIFICATE OF DEATH

Item 8 Film G290 - 7/6/61 jwk

06329

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: Fourth Avenue, Box 335
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: W. — Last: Asbury, Sr.

4. DATE OF DEATH: Month: June — Day: 27 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-16-1911 (If less than 1 day old, number of hours or minutes, or birthday) — Kentucky — 12/11/49 yrs.

IF UNDER 1 YEAR: Months: 1916 — Days: (foreign country)
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nat'l Plastic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City, town or county): Kentucky

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: James Asbury

14. MOTHER'S MAIDEN NAME: Millie Farmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 232-16-5891

17. INFORMANT: Walter W Asbury, Jr., Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
162.1
DUE TO (b): Bronchial carcinoma — 1 year.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March, 19 61 to 6/27, 19 61, that (I) (we) last saw the deceased alive on 6/27 19 61, and that death occured at 1:05 P.M. on the causes and on the date stated above.

22a. SIGNATURE: Gerard Church. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Gerard Church

22d. ADDRESS: Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 30 61

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven

23d. LOCATION (City, town or county) (State): Glen Burnie, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Hopping & Kirkley — **ADDRESS**: Glen Burnie

25a. REC'D BY REGISTRAR DATE JUL 3 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Knauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6345

CERTIFICATE OF DEATH

06330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL – Edgewater
d. STREET ADDRESS: Ruxton Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: E. — Last: ATKINSON

4. DATE OF DEATH: Month: June — Day: 3 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 6, 1909

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER

10b. KIND OF BUSINESS OR INDUSTRY: Stereotyper

11. BIRTHPLACE (County & State, or foreign country): Maine

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William N. Atkinson

14. MOTHER'S MAIDEN NAME: Georgina E. Lower

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dorothy L. Atkinson (2) — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Pulmonary Emboli — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Auricular fibrillation - flutter — 6 mos.
DUE TO (c): arteriosclerotic CVD — 10 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~no one~~) attended the deceased from May 23, 1961 to June 3, 1961, that (I) (~~no~~) last saw the deceased alive on June 3, 1961, and that death occured at 1:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/5/61

22c. PHYSICIAN'S NAME (Type): Frank M. Shipley

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-7-1961

23c. NAME OF CEMETERY OR CREMATORY: Puritan Lawn Memorial Park

23d. LOCATION (City, town or county) (State): West Peabody Mass.

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Sayler Sons — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: JUN 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C36 06331

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 16 N. LINDEN AVE.

2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 16 N. LINDEN AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSIE — Middle M. — Last BARNES

4. DATE OF DEATH: Month 6 — Day 11 — Year 1961

5 SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 12-20-1889

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11 BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GEORGE J. SCHAEFFER

14 MOTHER'S MAIDEN NAME: ELIZ ANN DOXZEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17 INFORMANT: JAMES W. BARNES — Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic C.V. Disease — 4 yrs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 4, 1961, to June 11, 1965 that (I) (we) last saw the deceased alive on June 11, 1965 and that death occurred at 6:15 P.M. from the causes and on the date stated above

22a SIGNATURE: Maurice F. Kinnamon, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 6/12/61

22c. PHYSICIAN'S NAME (Type): MAURICE F. KINNAMON, — 22d ADDRESS: 31 SOUTH GATE AV.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b DATE THEREOF: 6-14-61 — 23c NAME OF CEMETERY OR CREMATORY: ASBURY — 23d LOCATION (City, town or county): ARNOLD (State): MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John M. Boyd & Sons — ADDRESS: Annapolis, Md.

25a REC'D BY REGISTRAR DATE JUN 19 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kinnamon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6347

CERTIFICATE OF DEATH

Item 5, telephone call - Cecil Funeral Home - 6/13/61 mrs.

Reg. Dist. No. 06332

1. PLACE OF DEATH
a. COUNTY: AA — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: Aa

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ARNOLD

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold - Shoreacres

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Shoreacres

d. STREET ADDRESS: 1 Shoreacres

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: K. — Last: Beall

4. DATE OF DEATH: Month: 6 — Day: 10 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 9, 1889

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Diff

11. BIRTHPLACE (State or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Thomas Meaghin

14. MOTHER'S MAIDEN NAME: Mary Ann —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Hypertension - Nephritic Origin
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Secondary Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 16, 1961, to June 9, 1961 that I last saw the deceased alive on June 9, 1961, and that death occurred at 4:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos. Geo. Gidd M.D. ADDRESS (Street, city or town, state): Arnold - Maryland DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): B

22b. DATE THEREOF: 6-14-61

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.

22d. LOCATION (City, town, or county) (State): Glen Burnie

23. FUNERAL DIRECTOR'S SIGNATURE: Mc Cully Funeral Home ADDRESS: 130 E. Fortune Blvd

24a. REC'D BY REGISTRAR DATE: JUN 13 '61

24b REGISTRAR'S SIGNATURE: Lillian L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6348

CERTIFICATE OF DEATH

06333

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 1yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1029 Sharon Drive - Fairway Gardens

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Washington
b. COUNTY: Kitsap
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bremerton
d. STREET ADDRESS: 2104 E. 17th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Allie; Middle: ; Last: Beck

4. **DATE OF DEATH**: Month: June; Day: 24th; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 21st July 1894

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (County & State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph S. Beck

14. MOTHER'S MAIDEN NAME: Mattie Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Ruby Osborne
Address: Same As #1

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b): Myocardial Infarction — 7 months
DUE TO (c): Coronary Artery Heart Disease — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

I20.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Left Sided Hemiplegia due to Cerebral Infarction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from July, 1960 to June 24, 1961, that (I) ~~(the)~~ last saw the deceased alive on June 20 1961, and that death occured at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Hilary T. O'Herlihy M.D.

22b. DATE SIGNED: June 24 / 1961

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): HILARY T. O'HERLIHY

22d. ADDRESS: 5 Central Ave. Glen Burnie Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 26 June 1961

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cem.

23d. LOCATION (City, town or county) (State): Glen Burnie Md.

24. FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton, Glen Burnie Md.
ADDRESS

25a. REC'D BY REGISTRAR DATE: JUN 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed w the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

(4) (3)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7473 **CERTIFICATE OF DEATH** Reg. Dist. No. 07463

1 PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena -
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Rt. #1 - Box 186 - Sand Bar - Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena - Long Point
d. STREET ADDRESS: Rt. #1 Box 186 - Sand Bar - Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK — Middle WILLIAM — Last BORN
4. DATE OF DEATH: Month JUNE — Day 29 — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE - 8 - 1888
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Ret)
10b. KIND OF BUSINESS OR INDUSTRY: J. Dashore Co.
11. BIRTHPLACE (State or foreign country): Baltimore, md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown (Dec)
14. MOTHER'S MAIDEN NAME: Unknown (Dec)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 213-07-8655
17. INFORMANT: James W. Born — Address: 5302 Tramore Rd. Balto. 14, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: INSTANTANEOUS
4 20.1
DUE TO
(b): CORONARY SCLEROSIS — 10 YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE 18 19 61 to JUNE 29 19 61 that I last saw the deceased alive on JUNE 23 19 61, and that death occurred at 6:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M.D. — ADDRESS (Street, city or town, state): 8471 Ft. Smallwood Rd. — DATE SIGNED: 6/29/61
PHYSICIAN'S NAME (Type): J. BRADY SMITH — PASADENA, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-3-1961
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore - Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Singleton Funeral Home — Robert F. Cline — ADDRESS: - Glen Burnie, md.
24a. REC'D BY REGISTRAR DATE: JUL 17 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0349

CERTIFICATE OF DEATH

Reg. Dist. No. 06334

1. PLACE OF DEATH
a. COUNTY: Aa Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenburnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 502 Hamlin Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Aa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenburnie
d. STREET ADDRESS: 1502 Hamlin Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adele — Middle: S. — Last: Brady

4. DATE OF DEATH: Month: June — Day: 12 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jul 25 1879

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles A Seim

14. MOTHER'S MAIDEN NAME: Caroline Bruce Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mr Frank B Brady — Address: 205 Davis Ln #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease — years
DUE TO
(c): Senility — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 1960 to June 1961 that I last saw the deceased alive on May 1961, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest A Leipold M.D. — ADDRESS (Street, city or town, state): 425 S. Catalina Hwy — DATE SIGNED:

PHYSICIAN'S NAME (Type): ERNEST A LEIPOLD — Glen Burnie Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): 6/14/61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry J. Fechmer & Sons — ADDRESS: North & Penna Ave Balto 17, Md

24a. REC'D BY REGISTRAR: JUN 16 '61

24b. REGISTRAR'S SIGNATURE: Clinton S Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C250 06335

1. PLACE OF DEATH
a. COUNTY: A A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION: 702 Severn Ave

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md. — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1702 Severn Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Louise Middle K. Last Brooks
4. DATE OF DEATH: Month 6 Day 23 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-28-1871
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Karl Wyler
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: George T. Brooks — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Arteriosclerotic Heart Disease — 5 yrs.
DUE TO (c):
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1958 to 6-23-, 1961, that (I) (we) last saw the deceased alive on 6-23-1961, and that death occurred at 2:15 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M. D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6-26-61
22c. PHYSICIAN'S NAME (Type): JAMES R. MARTIN
22d. ADDRESS: ANNAPOLIS, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-26-1961
23c. NAME OF CEMETERY OR CREMATORY: Edwards Chapel
23d. LOCATION (City, town, or county) (State): Annapolis Md
24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: JUN 27 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6351 — 06336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): (Dead on arrival) Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 912 Wells Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Glenn; Middle: Tucker; Last: BROWN

4. DATE OF DEATH: Month: June; Day: 14; Year: 1961.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 2, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 5; Days: 12 — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Hunt Graham Brown

14. MOTHER'S MAIDEN NAME: Sylvia Anne Dodson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cong. Anal Atresia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Congenital Heart Disease Transposition

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~Attended~~) attended the deceased from Jan. 2, 1961 to June 14, 1961, that (I) (~~he~~) last saw the deceased alive on June 14, 19 61, and that death occured at 10:35 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Clayton Norton M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Clayton Norton

22d. ADDRESS: Medical Bldg., Severna Park, Md.

23a. BURIAL, ~~CREMATION~~ REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-17-61

23c. NAME OF CEMETERY OR CREMATORY: HILLCREST

23d. LOCATION (City, town or county) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Donald A. Taylor — ADDRESS: Annapolis, Md.

25e. REC'D BY REGISTRAR — DATE: JUN 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0352 06337

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Delaware
b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rehobeth Beach
d. STREET ADDRESS: 215 Philadelphia St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Adam; Middle: ; Last: BUNTEN

4. DATE OF DEATH: Month: June; Day: 19; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 3, 1891

9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Bunten

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO: ////////////

17. INFORMANT: Unknown

Address: Anaapolis, Md.

Mr. John Bunten (son) Cape St. Claire

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Recurrent attacks of coronary thrombosis — 15 years
DUE TO
(c): Generalized arterio-sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXXX~~) attended the deceased from June 18, 1961 to June 18, 1961, that (I) (~~XXX~~) last saw the deceased alive on June 18, 1961, and that death occured at 3:40 A.M., from the causes and on the date stated above

22a. SIGNATURE: Bertrand C. R. Gau

22b. DATE SIGNED: 6/19/61

22c. PHYSICIAN'S NAME (Type): Bertrand C. R. Gau

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Rt-4, Annapolis, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 21 st. June '61

23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

23d. LOCATION (City, town or county) (State): Glen Burnie, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: R. F. Singleton

ADDRESS: Glen Burnie, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 20 '61

25b. REGISTRAR'S SIGNATURE: Orlin S. Haas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6353 06338

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Edgewater
d. STREET ADDRESS: Rt-3, Box-207
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Burton — Last: COCKRELL
4. DATE OF DEATH: Month: June — Day: 1 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 31, 1961
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 2 — Min.: 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Thomas Cockrell, Jr.
14. MOTHER'S MAIDEN NAME: Mary Margaret Sweeney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~Attended~~) attended the deceased from May 31, 1961 to May 31, 1961, that (I) (~~Last~~) last saw the deceased alive on May 31, 1961, and that death occured at 1:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Niel H. Sims M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/2/61
22c. PHYS.CIAN'S NAME (Type): Niel H. Sims
22d. ADDRESS: 95 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/2/1961
23c. NAME OF CEMETERY OR CREMATORY: St Marys Cemt
23d. LOCATION (City, town or county): Annapolis (State): Md.
24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.
25a. REC'D BY REGISTRAR DATE: JUN 5 '61
25b. REGISTRAR'S SIGNATURE: Curtis L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6354 — 06339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND 8 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Edgewater
d. STREET ADDRESS: Rt-2, Box-130
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Caroline; Middle: ; Last: COLEMAN

4. DATE OF DEATH: Month: June; Day: 15; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-19-1897

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR — Months: ; Days: ; IF UNDER 24 HRS — Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Pratt

14. MOTHER'S MAIDEN NAME: Mary Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No
(If yes give wer or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Otis Truman Address: Edgewater Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Hemorrhage due to
DUE TO (b): Hypertension Cardiac Disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town) County) (State)

21. I certify that (I) attended the deceased from June 15, 1961 to June 15, 1961, that (I) last saw the deceased alive on June 15, 1961, and that death occured at 8:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R L Richardson

M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/16/61

22c. PHYSICIAN'S NAME (Type): R. L. Richardson

22d. ADDRESS: 110 Clay St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial 6-19-1961

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Chews

23d. LOCATION (City town or county) (State): West River Md.

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese

ADDRESS: Anna. Md.

25a. REC'D BY REGISTRAR DATE: JUN 19 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6255 06340

1. PLACE OF DEATH
a. COUNTY: Anne Anrundal
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 7 years
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. NAVAL HOSPITAL ANNAPOLIS MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Anrundal
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 30 Maryland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lee; Middle: Roy; Last: CONLEY

4. DATE OF DEATH: Month: June; Day: 2; Year: 1961

5. SEX: Male

6. COLOR OR RACE: CAUC

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 Aug. 1893

9. AGE (If years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months: ; Days:

IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Military Officer

10b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY

11. BIRTHPLACE (County & State, or foreign country): Jackson North Carolina

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Ute (N) CONLEY

14. MOTHER'S MAIDEN NAME: Newton Kizzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes
(If yes, give war or dates of service): WWI - WWII

16. SOCIAL SECURITY NO.: 220 30 0441

17. INFORMANT: Wife SUSAN K. CONLEY

Address: 30 Maryland Ave ANNAPOLIS, MARYLAND

18. CAUSE OF DEATH (Enter only one cause per line for (a), b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 14 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that ☒ (this hospital) attended the deceased from 29 Dec. ....., 1958 to 2 June ....., 1961, that ☐ (we) last saw the deceased alive on 11 May 1961, and that death occured at 8 PM, from the causes and on the date stated above.

22a. SIGNATURE: S Busch M.D.

22c. PHYSICIAN'S NAME (Type): S. BUSCH, LT MC USNR

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: USNH, Annapolis, Maryland

22b. DATE SIGNED: 3 JUNE 1961

23a. BURIAL, CREMATION, REMOVAL (Spec.fy): BURIAL

23b. DATE THEREOF: 6-6-61

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d. LOCATION (City, town or county): ARLINGTON (State): VA.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE JUN 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6356

CERTIFICATE OF DEATH

06341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN this place: 6 years 7mos. 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cornelia — Middle: — Last: Cooper

4. DATE OF DEATH: Month: 6 — Day: 28 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April, 1885?

9. AGE (In years last birthday): 76? yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (County & State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stover James

14. MOTHER'S MAIDEN NAME: Lula ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypostatic Pneumonia

334.X

DUE TO (b): ———

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ———

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized & Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): ———

20c. TIME OF INJURY: Month Day Year — Hour a.m. ——— p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———

20f. (City or town) (County) (State): ———

21. **I certify** that (I) (this hospital) attended the deceased from 11/26 ....., 1954., to 6/28 ....., 1961, that (I) (we) last saw the deceased alive on 6/28 ....., 1961., and that death occured at 6 P.M., from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict

MD — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 6/29/61

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 30 Jun 1961

23c. NAME OF CEMETERY OR CREMATORY: Univ. of Md

23d. LOCATION (City, town or county) (State): Balt. Md

24. FUNERAL DIRECTOR'S SIGNATURE: Wm. Reese II

ADDRESS: 108 W. Washington St Annapolis

25a. REC'D BY REGISTRAR: DATE JUL 3 '61

25b. REGISTRAR'S SIGNATURE: S. Friend

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C357 Items 13 & 14 Film G289 6/29/61 mh

06342

1 PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 512 New Jersey Ave. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Margaret; Middle: ; Last: CURTISS

4. DATE OF DEATH: Month: June; Day: 18; Year: 1961

5 SEX: Female

6 COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 18, 1910

9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Jacob M. Dicus

14. MOTHER'S MAIDEN NAME: Elver Stinchcomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT: Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage

DUE TO (b): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: a few days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(Did not)~~ attended the deceased from June 9, 1961 to June 18, 1961, that (I) ~~(Did not)~~ last saw the deceased alive on June 18, 1961, and that death occured at 8:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Harold M Shipley M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-19-61

22c. PHYSICIAN'S NAME (Type): HAROLD M SHIPLEY

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 6-21-61

23c. NAME OF CEMETERY OR CREMATORY: Baldwin Memorial

23d. LOCATION (City, town or county) (State): Millersville AA Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Hopping & Kirkley ADDRESS: Glen Burnie

25a. REC'D BY REGISTRAR DATE: JUN 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C359 06343

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Brooklyn Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5 W. Fifth Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Baltimore
d. STREET ADDRESS: 5 W. Fifth Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Alice Middle Behren Last Darby
4. DATE OF DEATH: Month June Day 22, Year 19 61

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 11, 1891
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Albert Behren
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Leslie W. Darby — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cacchexia - Metastatic Carcinoma
175.0
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Left Ovarian Carcinoma
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1961, to 22 June 1961, that (I) (we) last saw the deceased alive on 22 June 1961, and that death occurred at 7P M, from the causes and on the date stated above

22a. SIGNATURE: Andrew R. Sosnowski M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: June 23, 1961
22c. PHYSICIAN'S NAME (Type): Andrew R. Sosnowski
22d. ADDRESS: 4016 Ritchie Hgwy., Baltimore 25, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 26, 1961
23c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Pk.
23d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: George J. Gonce
ADDRESS: 4001 Ritchie Hwy. (25)
25a. REC'D BY REGISTRAR DATE: JUN 27 '61
25b. REGISTRAR'S SIGNATURE:

George J. Gonce

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6359 — 06344

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN this place: 18 years 8mos. 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reliance
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: — Last: Dashiell

4. DATE OF DEATH: Month: 6 — Day: 14 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 1903

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wesley Dashiell

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Unknown — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Internal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Stomach Ulcer

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): General Paresis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY: Hour a.m. p.m. ------ Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that (I) (this hospital) attended the deceased from 9/24 19 42 a.m. to 6/14 19 61, that (I) (we) last saw the deceased alive on 6/14 19 61, and that death occured at 6:30 a.m., from the causes and on the date stated above.

22a. SIGNATURE: L Benedict M.D.

22b. DATE SIGNED: 6/14/61

22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/17/1961

23c. NAME OF CEMETERY OR CREMATORY: Fruitland

23d. LOCATION (City, town or county, State): Fruitland Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Chester F. Stewart Salisbury Md.

25a. RECD BY REG STRAR DATE: JUN 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 18 Film 290 7-6-61
18 Film 291 7-27-61

1

FOR STATE HEALTH DEPT.

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2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0260

06345

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 429 - 1st Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RUBY — Middle L. — Last DePREMO

4. DATE OF DEATH: Month June — Day 23 — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 30, 1933

9. AGE (In years last birthday): 28 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John L Gibson

14. MOTHER'S MAIDEN NAME: Mary C. Wootsen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

(If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Joseph DePremao - Husband- same as # 2
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocarditis, Isolated // Cerebral edema

DUE TO

250x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): due to Colloid cyst of third ventricle, with obstruction of foramina of Monro

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

Address (Street, city, town, or county)

DATE SIGNED: 6/23/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 26, 1961

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or country) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR: Hopping Funeral Home

ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR: JUN 28 61
DATE

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO COUNTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Item 20b Film 291 7-27-61

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C362 06346

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4413 Elderon Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First EDWIN — Middle A. — Last EASON

4. DATE OF DEATH: Month June — Day 22 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 18, 1898

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Claims Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Nationwide Ins.

11. BIRTHPLACE (State or foreign country): North Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Eason

14. MOTHER'S MAIDEN NAME: Lois ? Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 275-03-6734

17. INFORMANT: Marian A. Eason — Address: 4413 Elderon Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Blunt-force head injury
819X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of auto in auto-auto collision & fixed object.

20c. TIME OF INJURY: Hour 5:20 p.m. — Month, Day, Year 6/22 1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Road

20f. (City or town): Arnold — (County): Anne Arundel — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Bradley King, Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 6/23/61

EXAMINER'S NAME (Type): W. Bradley King, Jr., M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/26/61

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

22d. LOCATION (City, town, or country): Woodlawn, Maryland (State):

23. FUNERAL DIRECTOR: Ellsworth Armacost

ADDRESS: 4600 Liberty Hghts. Ave.

24a. REC'D BY REGISTRAR — DATE: JUN 26 '61

24b. REGISTRAR'S SIGNATURE: Evelyn L. Kraus

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

€362

CERTIFICATE OF DEATH

Reg. Dist. No. 06347

1 PLACE OF DEATH
a. COUNTY: A. A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Route 4, Box 106, Annapolis
c. LENGTH OF STAY IN 1b: 10 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt 4, Box 106, Annapolis,
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ellen — Middle: Louise — Last: ELLIS

4. DATE OF DEATH: Month: June — Day: 25 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 26, 1914

9. AGE (In years last birthday): 46 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Cheltenham, Md.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Charles O. C. Rawlings

14. MOTHER'S MAIDEN NAME: Pearl V. Colbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: J. Harold Ellis Route 4, Box 106, Annoplis Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): unKnown coronary thrombosis ? — INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) generalized arteriosclerosis + hypertension — 5 years

DUE TO

(c) obesity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebrovascular accident in december 1960

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-21, 1960 to 6-5, 1961 that I last saw the deceased alive on 6-5, 1961, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bertrand C.R. Gau M.D.

ADDRESS (Street, city or town, state): BERTRAND C. R. GAU — ~~RIVER BAY ROAD~~ CAPE ST. CLAIRE RT. 4, ANNAPOLIS, MD.

DATE SIGNED: 6/25/61

PHYSICIAN'S NAME (Type): Bertram C. R. Gau, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/27/61

22c. NAME OF CEMETERY OR CREMATORY: Tayman Family Plot

22d. LOCATION (City, town, or county) (State): Cheltenham Md.

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ritchie Brothers Fun'l Home Upper Marlboro, Md.

24a REC'D BY REGISTRAR — DATE: JUN 29 '61

24b REGISTRAR'S SIGNATURE: Clifton E. Knott

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

€363 **CERTIFICATE OF DEATH** 07481

Items 11 & 12 Film 6290 - 7/13/61 WR

1. PLACE OF DEATH
a. COUNTY: 17
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shadyside
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Va
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mdnassas, Fairfax
d. STREET ADDRESS: RT 3 Box 120
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Lorena	Heishmen	Ellis		6	29	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W		Jan 5 1903	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Title Insurance Exp.
10b. KIND OF BUSINESS OR INDUSTRY: Mortgage Title Ins
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph H Heishmen
14. MOTHER'S MAIDEN NAME: Annie Florence Vetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	
DUE TO (b)	Coronary artery disease	
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from ... not at all ... 19 ., to ..... 19....., that (I) (we) last saw the deceased alive on .... Not at all .... 19 ..., and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Emily H. Heishmen M.D
22b. DATE SIGNED
ATTEND NG PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐ Coroner
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	7-3-61	National Memorial Park Falls Church	Va

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty
ADDRESS: Gaithersburg Md

25a. REC'D BY REGISTRAR DATE JUL 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ex... d within 24 hours after ... age 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6364 Reg. Dist. No. 06348

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 311 CHESAPEAKE AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 311 CHESAPEAKE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PEARL Middle M. Last EVANS
4. DATE OF DEATH: Month 6 Day 10 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-26-1883
9. AGE (In years if over 1 day): 67 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LOUIS MELCHER
14. MOTHER'S MAIDEN NAME: GRACE NORWOOD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT: EARLE EVANS Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: Hours
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. LINHARDT
DATE SIGNED: 6-10-61.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6/13/61
22c. NAME OF CEMETERY OR CREMATORY: HILLCREST
22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD.
23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: JUN 19 '61
24b. REGISTRAR'S SIGNATURE: Clifton B. Parran

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(S)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6365

Reg. Dist. No. 06349

1. PLACE OF DEATH
a. COUNTY Anne Arundel, MARYLAND
b. CITY OR TOWN (If outside corporate limits so state RURAL and give nearest town) Fairhaven
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland b. COUNTY A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairhaven, Md.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Donald Middle Last Eversfield

4. DATE OF DEATH Month June Day 17 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH [illegible] 1936

9. AGE (In years last birthday) 25 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) College Park, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME [illegible] Eversfield

14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-30-[illegible]

17. INFORMANT Address
Mrs. Anne E. Eversfield Fair[illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fractured cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b)
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple fractured ribs, Cerebral Concussion, Multiple Contusions

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS INJURY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Tractor overturned and fell on patient

20c. TIME OF INJURY Hour 6 p.m. Month, Day, Year June 17 1961

20d. INJURY OCCURRED While at work [X] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm

20f. (City or town) Fairhaven (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Willard F. Smith M.D.

EXAMINER'S NAME (Type) WILLARD F. SMITH, MD

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED 6/18/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 6/20/61

22c. NAME OF CEMETERY OR CREMATORY [illegible]

22d. LOCATION (City, town, or county), (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS [illegible]

24a. REC'D BY REGISTRAR DATE JUN 26 '61

24b. REGISTRAR'S SIGNATURE Willard F. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be obtained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1365 06350

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
c. LENGTH OF STAY IN this MARYLAND: 10 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): #558 Forest View Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linthicum Heights
d. STREET ADDRESS: #558 Forest View Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KENNETH Middle N. Last FAIR

4. DATE OF DEATH: Month June Day 5th Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 18th April 1914

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Calvert Distillery

11. BIRTHPLACE (State or foreign country): Schaller, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James E. Fair

14. MOTHER'S MAIDEN NAME: Nona Noll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): yes W.W. II

16. SOCIAL SECURITY NO.: 050 01 4698

17. INFORMANT: Mrs. Minerva K. Fair
Address: Same As #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO (b): 420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert MD M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

Address (Street, city, town, or county)

DATE SIGNED: 5th June 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10th June '61

22c. NAME OF CEMETERY OR CREMATORY: Ida Grove Cemetery

22d. LOCATION (City, town, or country) (State): Ida Grove, Iowa

23. FUNERAL DIRECTOR: Richard F. Singleton
ADDRESS: Glen Burnie, Maryland

24a. REC'D BY REGISTRAR DATE JUN 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6367 06351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1. **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: United States Army Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 1920 Norman Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JAMES — Middle CHARLES — Last FATH

4. **DATE OF DEATH**: Month JUNE — Day 21 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4:45 AM 21 June 61

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours 16 — Min 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gordon A. Fath

14. MOTHER'S MAIDEN NAME: Barbara Harmon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. **INFORMANT** Address: Father: 1920 Norman Rd Glen Burnie, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.

P76X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~this physician~~ attended the deceased from birth 21 June 61 to _____ 19 _____, that (I) (we) last saw the deceased alive on 21 June 19 61, and that death occurred at 7:20 P.m. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M D

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 21 June 61

22c. PHYSICIAN'S NAME (Type): ROY M. SLEZAK, Capt., M.C.

22d. ADDRESS: USA Hosp Ft Geo G. Meade, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 23/61

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town, or county) (State): Baltimore - Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Earl B Wolfington Funeral Home, Inc 6306 Belair Rd, Baltimore-6, Md

25a. REC'D BY REGISTRAR DATE: JUN 27 '61

25b. REGISTRAR'S SIGNATURE: [signature]

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0368 — 06352

1. PLACE OF DEATH
a. COUNTY: Allo
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Selby on Bay
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.H. Anne Arundel Gen

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville - Md
d. STREET ADDRESS: 7701 Reforme Highway
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: H — Last: Ferrar

DATE OF DEATH: Month: 6 — Day: 10 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 1, 1900

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor Foreman

10b. KIND OF BUSINESS OR INDUSTRY: C & P Telephone Co.

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Ferrar

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dora E. Ferrar — Address: 7701 Reforme Highway Hyattsville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

434.4

INTERVAL BETWEEN ONSET AND DEATH: Months — Days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. F. Wheatley M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): E. F. Wheatley

Address (Street, city, town, or county):

DATE SIGNED: 6-10-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 13-1961

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Prince George Md

23. FUNERAL DIRECTOR: J. Arthur Walters

ADDRESS: 254 Creek St NC

24a. REC'D BY REGISTRAR DATE: JUN 13 '61

24b. REGISTRAR'S SIGNATURE: Clifford L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C369 — 06353

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 211 Wardour Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: L. — Last: Foster

4. DATE OF DEATH: Month: June — Day: 29 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-9-1898

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Professor U.S.N.A.

10b. KIND OF BUSINESS OR INDUSTRY: Physical Ed.

11. BIRTHPLACE (County & State, or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank E. Foster

14. MOTHER'S MAIDEN NAME: Murmie E. Keller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.:

17. INFORMANT: William Morgan — Address: #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suicide — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): multiple duodenal ulcers

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-16-61, 19__ to 6-29-61, 19__ that (I) (we) last saw the deceased alive on 6-29-61 and that death occured at 6:33 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-29-61

22c. PHYSICIAN'S NAME (Type): FRANK M SHIPLEY

22d. ADDRESS: Annapolis, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 7-3-61

23c. NAME OF CEMETERY OR CREMATORY: NAVAL ACADEMY

23d. LOCATION (City, town or county) (State): ANNAPOLIS MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUN 30 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Knaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6370

06354

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 2 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marley Park

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Sane — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: / Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Annie — Middle B. — Last Green
4. DATE OF DEATH: Month 6/7/61 — Day — Year 19

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): A.A.County Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Hall
14. MOTHER'S MAIDEN NAME: Ellen Kess

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: CLIFTON — Address: Mrs/ Charles Green (son) Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-hypertensive vascular diseases. — INTERVAL BETWEEN ONSET AND DEATH: ?
443X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from May 30 19 61 to 6/7/61 19 , that (I) (we) last saw the deceased alive on 6/6/61 19 , and that death occurred at 7 AM, from the causes and on the date stated above.

22a SIGNATURE: Gustave H Faubert M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 6/9/61
22c. PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D.
22d. ADDRESS: Glen Burnie, Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/11/61
23c. NAME OF CEMETERY OR CREMATORY: Mt Zion Church
23d. LOCATION (City, town or county) (State): Magothy - Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Marshall P. Hayes 638 N. Gilmor St Balto Md
25a. FILED BY REGISTRAR DATE: JUN 12 61
25b. REGISTRAR'S SIGNATURE: Clifton T. Perkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6371

CERTIFICATE OF DEATH

06355

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, not later than 72 hours after death.

VR A15 (4)
15M 9/60

1 **PLACE OF DEATH**
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 65 Franklin Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rose; Middle: ; Last: GREENFIELD
4. DATE OF DEATH: Month: 6; Day: 17; Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 1880
9. AGE (In years last birthday): 81 yrs; IF UNDER 1 YEAR: Months: Days: ; IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): Riga, Latvia
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Files — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS
Y-10.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELITUS; PERSISTENT CONGESTIVE FAILURE
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-4 ., 1961, to 6-17 ., 1961, that (I) (We) last saw the deceased alive on 6-16 1961., and that death occured at 12 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward S Beck M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Edward S. Beck, M.D.
22d. ADDRESS: 73 Franklin Street, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 18, 61
23c. NAME OF CEMETERY OR CREMATORY: Kneseth Israel
23d. LOCATION (City, town or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.
25a. REC'D BY REGISTRAR DATE: JUN 20 '61
25b. REGISTRAR'S SIGNATURE: Clinton S Hanna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6372 Reg. Dist. No. 06356

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Box 216
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Edgewater

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Box 216
d. STREET ADDRESS: Edgewater
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lizzie — Middle: Marshall — Last: Harris

4. DATE OF DEATH: Month: June — Day: 13 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 13-1881

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ********

11. BIRTHPLACE (State or foreign country): A.A.Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: William O. Harris- Edgewater, Md. Box 216

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
434.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE OF M.D.: [signature] — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): E. Lingenfelter — DATE SIGNED: 6/15/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-16-61
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C.E.Hicks III — ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 20 '61

24b. REGISTRAR'S SIGNATURE: Cirilus L. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If [illegible] delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the [illegible] director. Page 4 should be [illegible] to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for [illegible] files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6373 Item 8 Film C290 11/1/61 ivk 06357

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 143 Riverview Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle: W.; Last: Haughton

4. DATE OF DEATH: Month: June; Day: 27; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. June 19, 89

9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Brush Door to Door

11. BIRTHPLACE (State, or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Haughton

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 212 30 1900

17. INFORMANT: Mrs. Josephine L. Haughton Address: Wife same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 177X
DUE TO (b): Asperation pneumonitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hemi - paralysis
Prostatic carcinoma

INTERVAL BETWEEN ONSET AND DEATH:
(a) 24 hours.
(b) 24 hours.
(c) 6 months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paralysis Agitans

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from S.A.H. 19 61 to 6/27 19 61, that (I) (we) last saw the deceased alive on 6/27 19 61, and that death occured at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: G.H. Church

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Gerard Church

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 30, 61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery

23d. LOCATION (City, town or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUN 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

Item 18 Film 290 7-5-61 ans

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06358

1 FOR STATE HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9 60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Odenton
c. LENGTH OF STAY IN 1b: few hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Whitmore Tavern, Route #175

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: A. A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
d. STREET ADDRESS: Route #1, Box 221-B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wylie — Middle — Last Hawthorn

4. DATE OF DEATH: Month June — Day 15 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/10/09

9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Engineer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pollell, Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jefferson Hawthorn

14. MOTHER'S MAIDEN NAME: L. A. Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, war or dates of service) W. W. II

16. SOCIAL SECURITY NO.: 578-07-4264

17. INFORMANT: Mrs. Raymond Singleton Jr. (daughter) — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspect on ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William V. Lovitt, Jr., M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): William V. Lovitt, Jr., M.D.

Address (Street, city, town, or county):

DATE SIGNED: June 16, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 19 June 61

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Park

22d. LOCATION (City, town, or country): Glen Burnie Maryland (State)

23. FUNERAL DIRECTOR: Hopping & Kirkley Funeral Home

ADDRESS:

24a. REC'D BY REGISTRAR — DATE: JUN 20 '61

24b. REGISTRAR'S SIGNATURE: Charles L. Travis

1

FOR STATE HEALTH DEPT.

M

X

1

29

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6375 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 06359

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: Over 5 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mt. Pleasant Beach

2. USUAL RESIDENCE (Where deceased lived, If institutional: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Andrew — Middle E. — Last Haynie

4. DATE OF DEATH: Month June — Day 26th, — Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/17/99

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Copper Koppers Co.

11. BIRTHPLACE (State or foreign country): Virginia.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andres Jackson Haynie

14. MOTHER'S MAIDEN NAME: Elizabeth Jane Buchanan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 216-10-9898

17. INFORMANT — Address: Mrs. Florence Haynei (wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): Pulmonary Emphysema — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Chronic Bronchisits — ?

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 6/27/61

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

Address (Street, city, town, or county) (State): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/29/61

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Mem. Pk.

22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR — ADDRESS: JOHN F. DENNY, INC. 715 Light St.

24a. REC'D BY REGISTRAR — DATE: JUN 28 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Hines

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C375

CERTIFICATE OF DEATH

06360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1C Annapolis
d. STREET ADDRESS: 12 North Woodlawn Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Middle: Boy Last: Hendricks

4. DATE OF DEATH: Month: June Day: 30 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: 1 IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Marshall E. Hendricks

14. MOTHER'S MAIDEN NAME: Margaret Mutchler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Prematurity

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-29, 1961 to 6-30, 1961, that (I) (we) last saw the deceased alive on 6-30, 1961, and that death occured at 10:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Clayton Norton M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Dr. Clayton Norton

22d. ADDRESS: Severna Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 1, 61

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.

23d. LOCATION (City, town or county) (State): Annapolis Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hepping F. Hall ADDRESS: Home Annapolis

25a. REC'D BY REGISTRAR DATE: JUL 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6377 06361

1. PLACE OF DEATH a. COUNTY: A A. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 106 Shirley St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 106 Shirley St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roy Middle: E. Last: Hopkins
4. DATE OF DEATH: Month: June Day: 29 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar 22nd 1916
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10b. KIND OF BUSINESS OR INDUSTRY: Aberdeen Prov. Grounds
11. BIRTHPLACE (State or foreign country): Annapolis Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas S. Hopkins
14. MOTHER'S MAIDEN NAME: May M. Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Thomas S. Hopkins Address: 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1, 1961, to June 2, 1961, that (I) (we) last saw the deceased alive on June 1 1961, and that death occurred at 8:52 A.M. from the causes and on the date stated above

22a. SIGNATURE: John L. Henderson M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 6/3/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-5-1961
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
23d. LOCATION (City, town, or county): Annapolis (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Son ADDRESS: Annapolis Md
25a. REC'D BY REGISTRAR DATE: JUN 5 '61
25b. REGISTRAR'S SIGNATURE: Carolyn L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT5 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6378 06362

1. PLACE OF DEATH
a. COUNTY Anne-Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millerville
c. LENGTH OF STAY IN 1b 65 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jumper Hole , Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Anne-Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville
d. STREET ADDRESS Jumper Hole Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Millikin Middle Hudson Last
4. DATE OF DEATH Month June Day 17 Year 19 61

5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 15,1888
9. AGE (In years last birthday) 72 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Enfield , N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Hudson
14. MOTHER'S MAIDEN NAME Jane Hudson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-14-8702
17. INFORMANT Address Mrs. Bertha V. Hudson, Same as Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: over 6 years
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 1955, to June 16, 1961, that (I) (we) last saw the deceased alive on June 16th 19 61 and that death occurred at 8 P.M. from the causes and on the date stated above

22a. SIGNATURE Gustave H. Faubert M.D. M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 6/20th/61
22c. PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.
22d ADDRESS Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 6/21/61
23c. NAME OF CEMETERY OR CREMATORY Hall's Cemetery
23d LOCATION (City, town, or county) (State) A. A. Co. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William A. Jackson Funeral Home 916 Penna. Ave. # 1
25a. REC'D BY REGISTRAR DATE JUN 21 '61
25b. REGISTRAR'S SIGNATURE Clifton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6379

CERTIFICATE OF DEATH

06363

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 150 Carroll Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle: — Last: Humphreys

4. DATE OF DEATH: Month: June — Day: 28 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 27, 1961

9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months: — Days: 1 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert N. Humphreys

14. MOTHER'S MAIDEN NAME: Katherine Delores McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): goldmaturity — INTERVAL BETWEEN ONSET AND DEATH: 1 day

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from June 27, 19 61 to June 28, 19 61, that (I) (we) last saw the deceased alive on June 28, 19 61, and that death occured at 1 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Neil H. Sims M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Dr. Neil Sims

22d. ADDRESS: Cathedral St. Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 30, 61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town or county) (State): Baltimore 25, Md

24 FUNERAL DIRECTOR'S SIGNATURE: J. Kirkley — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: JUL 3 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6390

CERTIFICATE OF DEATH

Reg. Dist. No. 06364

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
c. LENGTH OF STAY IN 1b: 38 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Rt. #175 N/A Dairy Farm

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
d. STREET ADDRESS: Rt. #175 - N/A Dairy Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN — Middle A. — Last HUTCHINS, Sr.

4. DATE OF DEATH: Month June — Day 10 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2nd. Aug. '03

9. AGE (In years last birthday): 57 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendant

10b. KIND OF BUSINESS OR INDUSTRY: N/A Dairy Farm

11. BIRTHPLACE (State or foreign country): Eastport, Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Francis D. Hutchins

14. MOTHER'S MAIDEN NAME: (Mamie) Mary P. Norfolk

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ////////

16. SOCIAL SECURITY NO: 220 16 5220

17 INFORMANT: Mrs. Catherine W. Hutchins, — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Half Hour

420.1

DUE TO (b): Sclerotic Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d INJURY OCCURRED While at work [ ] Not while at work [ ]

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1958 to June, 1961, that I last saw the deceased alive on June 10 1961, and that death occurred at 5.45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Felix Gruenberg M.D. ADDRESS (Street, city or town, state): 6090 Dutton Rd - DATE SIGNED: 6/12/61

PHYSICIAN'S NAME (Type): Felix Gruenberg. 6090 Dutton Rd

22a. BURIAL CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 13th June '61

22c. NAME OF CEMETERY OR CREMATORY: Baldwin Mem. Ch. Cem.

22d. LOCATION (City, town, or county) (State): Millersville, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Richard V. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: JUN 15 '61

24b. REGISTRAR'S SIGNATURE: Anthony L. Young

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6381

CERTIFICATE OF DEATH

06365

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: MARYLAND 3 years 3 mos. 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: 323 Port Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Tilghman; Middle: Elmer; Last: Jenkins
4. DATE OF DEATH: Month: 6; Day: 20; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: December 3, 1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Worker
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William Henry Jenkins
14. MOTHER'S MAIDEN NAME: Christinia Adams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1918-1919
16. SOCIAL SECURITY NO.: 130-01-8285
17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Nephrosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Hemorrhage

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY: Hour ---------- a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.): ----------
20f. (City or town) (County) (State): ----------

21. I certify that (I) (this hospital) attended the deceased from 3/19 1958, to 6/20 1961, that (I) (we) last saw the deceased alive on 6/20 1961, and that death occured at 2:33 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L. Benedict M.D.
22b. DATE SIGNED: 6/20/61
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): L. Benedict, M. D.
22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/22/61
23c. NAME OF CEMETERY OR CREMATORY: Richardson Cem.
23d. LOCATION (City, town or county): Easton Md.
(State):

24. FUNERAL DIRECTOR'S SIGNATURE: Charles B. Dukes Jr.
ADDRESS: Easton Md.
25a. REC'D BY REGISTRAR: DATE JUN 23 '61
25b. REGISTRAR'S SIGNATURE: Charles S. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6382

CERTIFICATE OF DEATH

Reg. Dist. No. 06366

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: United States Army Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2331 Lorretta Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: JOHNSON

4. DATE OF DEATH: Month: JUNE Day: 1 Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Neg

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 1 June 61 3:20 AM

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months: Days: Hours: 4 Min: 50
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Louis Johnson

14. MOTHER'S MAIDEN NAME: Hattie Creech

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT Address: Mother 2331 Lorretta Ave Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Immaturity — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3:20 AM 1 June 19 61 to 8:10 A M 1 June 19 61, that I last saw the deceased alive on 1 June 19 61, and that death occurred at 8:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sherman S. Robinson M.D.

ADDRESS (Street, city or town, state): USA Hosp Ft Geo G Meade, Md.

DATE SIGNED: 1 June 61

PHYSICIAN'S NAME (Type): SHERMAN S. ROBINSON, Capt., M.C.

22a. ~~BURIAL~~ CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 7 June 61

22c. NAME OF CEMETERY OR CREMATORY: USA Hosp LABORATORY

22d. LOCATION (City, town, or county) (State): Ft. Geo. G. Meade Md

23. FUNERAL DIRECTOR'S SIGNATURE: Shirley J. Linden — ADDRESS: Ft Geo G Meade Md

24a. REC'D BY REGISTRAR DATE JUN 9 '61

24b. REGISTRAR'S SIGNATURE: Irving S. Kraus

MSC 2nd Lt 2,050 172 XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6383

CERTIFICATE OF DEATH

Reg. Dist. No. 06367

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 7 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 107 4th Ave. S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Glen Burnie
d. STREET ADDRESS: 107 4th Ave S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Katherine — Last: Kearney

4. DATE OF DEATH: Month: June — Day: 10, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 25, 1915

9. AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookeeper

10b. KIND OF BUSINESS OR INDUSTRY: Westinghouse

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William J. Kelly

14. MOTHER'S MAIDEN NAME: Anna Marie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO: 214-18-6624

17. INFORMANT — Address: Mr. Edward Kearney

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): 170X

DUE TO (b): Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: 8 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1961, to June, 1961, that I last saw the deceased alive on June 10, 1961, and that death occurred at 6:00PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: C R MacDonald M.D. M.D.
ADDRESS (Street, city or town, state): 202 Crain Hwy S.W.
DATE SIGNED: June 11/61

PHYSICIAN'S NAME (Type): C. R. MacDonald M.D.
Glen Burnie Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: June 14,1961

22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Cemetery

22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: P. F. Livingston
ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: JUN 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6384 — 06368

FOR STATE HEALTH DEPT.

M

1

1. PLACE OF DEATH
a. COUNTY: P.G. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hospital
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D. C. 49X-3
d. STREET ADDRESS: 4201-Mass Ave-N.W. Apt. 709 3W — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marguerite — Middle: — Last: Lindauer

4. DATE OF DEATH: Month: 6 — Day: 24 — Year: 1961

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 4-23-09 — 9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prof. Social Worker — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Oregon — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Louis P. Mauzy — 14. MOTHER'S MAIDEN NAME: Etta Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no — 16. SOCIAL SECURITY NO.: 579-48-8825 — 17. INFORMANT: Frederick J. Lindauer — Address: same 2-d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: Sudden.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt M D
EXAMINER'S NAME (Type): E. Linhardt.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 6/24/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 6/27/61 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — 22d. LOCATION (City, town, or country) (State): Prince Georges Co. Md.

23. FUNERAL DIRECTOR — ADDRESS: The S. H. Hines Company Washington, D.C. — 24a. REC'D BY REGISTRAR: JUN 27 '61 — 24b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. Any delay is necessary, please notify funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6333 06369

Items 8 & 9 trim Geo. 7/1/61 iwk

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: AnneArundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 7 Morris St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Perry — Middle: — Last: McGOWAN

4. DATE OF DEATH: Month: June — Day: 21 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 8, 1879

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ROBERT McGOWAN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service):

16. SOCIAL SECURITY NO.: 218-14-3481

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebal Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Hypertensive cardiovascular disease — 7 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Generalized arteriosclerosis — 7 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: / 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXX~~) attended the deceased from June 14, 19 54 to June 21, 1961, that (I) (~~XXX~~) last saw the deceased alive on June 21, 1961, and that death occured at 1:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Theodore H. Johnson MD — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: June 23, 1961

22c. PHYSICIAN'S NAME (Type): Theodore H. Johnson, M. D. — 22d. ADDRESS: 37 Calvert St., Annapolis, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 6-25-61 — 23c. NAME OF CEMETERY OR CREMATORY: Brewer Hill Cem't — 23d. LOCATION (City, town or county) (State): Annapolis Md

24 FUNERAL DIRECTOR'S SIGNATURE: James H. Johnson — ADDRESS: Annapolis MD — 25a. REC'D BY REGISTRAR DATE: JUN 28 '61 — 25b. REGISTRAR'S SIGNATURE: Carthon L. Graves

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completely filled in by the funeral director, and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C285 06370

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): P.O. Severna Park
c. LENGTH OF STAY IN 1b: 7 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Earleigh Heights

2. USUAL RESIDENCE (Where deceased lived, If institution: Res dence before admiss on)
a. STATE: Md. Same
b. COUNTY: ~~Same~~ Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Same~~ P.O. Severna Park
d. STREET ADDRESS: ~~Same~~ Earleigh Heights
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): Clifford Heath Mc Neil (First / Middle / Last)

4. DATE OF DEATH: June 16th. 1961 (Month / Day / Year)

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/5/93

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Panama

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles McNeil

14. MOTHER'S MAIDEN NAME: Ada Sophia Heath

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 117-03-0235

17. INFORMANT (Address): Sudie Virginia McNeil(Common law wife)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
4201
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. / Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

M.D

DATE SIGNED: 6/16/61

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

Address (Street, city, town, or county): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6.20.61

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvery

22d. LOCATION (City, town, or country) (State): Arnold Md.

23. FUNERAL DIRECTOR: William Reese # Anna Md.

ADDRESS

24a. REC'D BY REGISTRAR DATE JUN 19 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

Item 18 Film 288
6-16-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C387 06371

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN this place: 8 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL – Annapolis
d. STREET ADDRESS: Rt-3, Box-419
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First (Twin B) Middle — Last MEIKLEJOHN

4. DATE OF DEATH: Month June Day 5 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours 7 Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Donald Meiklejohn

14. MOTHER'S MAIDEN NAME: Jessie May Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Hospital records — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac & Respiratory failure
DUE TO (b): Immaturity
DUE TO (c): Premature labor
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

773.5

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, off ca bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~the physician~~) attended the deceased from June 4, 1961, to June 5, 19.61, that (I) (~~he~~) last saw the deceased alive on June 5, 19.61, and that death occured at 3:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm. P. Stephens M.D.

ATTENDING PHYS. XX MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/6/61

22c. PHYSICIAN'S NAME (Type): William P. Stephens

22d. ADDRESS: 38 Cornhill St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

25a. REC'D BY REGISTRAR DATE JUN 8 '61

25b. REGISTRAR'S SIGNATURE: Oliver L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6388 **CERTIFICATE OF DEATH** 06372

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 222 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David; Middle:; Last: MYERS

4. DATE OF DEATH: Month: June; Day: 13; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 4, 1909

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Prop.

10b. KIND OF BUSINESS OR INDUSTRY: Tavern

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: David V. Myers

14. MOTHER'S MAIDEN NAME: Grace Meeks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes WW II

16. SOCIAL SECURITY NO.: 219 03 5209

17. INFORMANT: Mrs. Helen B. Myers, Wife- same as # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
331X
INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~Coroner~~) attended the deceased from 6-12, 19 61, to June 13, 1961, that (I) (~~He~~) last saw the deceased alive on June 13, 19 61, and that death occured at 11:55 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank M Shipley — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): Frank M. Shipley

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL, (Specify): Burial

23b. DATE THEREOF: June 16,61

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cemet.

23d. LOCATION (City, town or county) (State): Annapolis, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hopping Funeral Home — Annapolis, Maryland

25a. REC'D BY REGISTRAR — DATE: JUN 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuhn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6389 — Reg. Dist. No. 06373

1. PLACE OF DEATH
a. COUNTY: A.A.Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pikesville 8
d. STREET ADDRESS: 710 Liberty Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Melvin — Middle: R — Last: Myers
4. DATE OF DEATH: Month: 6 — Day: 30 — Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-7-1931
9. AGE (In years last birthday): 30 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Firefighter
10b. KIND OF BUSINESS OR INDUSTRY: Balto. City Fire Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond N. Myers
14. MOTHER'S MAIDEN NAME: Elsie L. Eaton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Joan E. Myers — Address: 4553 Reisterstown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
50 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Boat turned over —
20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: C-30 1961
20d. INJURY OCCURRED: While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chesapeake Manor
20f. (City or town): A.A.Co (County) MD (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. Linhardt M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type): E. Linhardt
DATE SIGNED: 6-30-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-3-61
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Leroy Byers
ADDRESS: 8728 Liberty Rd. Randallstown, Md.
24a. REC'D BY REGISTRAR DATE: JUL 5 '61
24b. REGISTRAR'S SIGNATURE: William E. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6390 Item 9 Film Grey 6/24/61 jdr 06374

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: Anne Arundel County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: All life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ft. Meade Rd., Box 179-B

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Same
b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Ezekiel — Middle: — Last: Oliver

4. DATE OF DEATH: Month: June — Day: 15, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 7/4/91

9. AGE (In years last birthday): 69 70 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): A.A.Co., Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Israel Oliver

14. MOTHER'S MAIDEN NAME: Armiger Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes — W.W. I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dennis Oliver, (Nephew) — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Burtal L Faubert M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): G. H. Faubert, M. D.

Address (Street, city, town, or county):

6/15/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-1)-61

22c. NAME OF CEMETERY OR CREMATORY: Baltimore, National

22d. LOCATION (City, town, or country) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR — ADDRESS: William A. Jackson Funeral Home Inc. 910 Pennsylvania Ave. Balto. 1, Md.

24a. REC'D BY REGISTRAR — DATE: JUN 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C391 — 06375

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: MARYLAND / Hrs;
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 26 Clay St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Clifton — Last: PARKER

4. DATE OF DEATH: Month: June — Day: 12 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 28, 1908

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern Keeper

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: James Parker, Sr

14. MOTHER'S MAIDEN NAME: Katie Mc Gowan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-16-2235

17. INFORMANT: Marie Pointer — Address: 100 W. Washington St Annapo

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 331 ✗
DUE TO (b): Massive Cerebral Hemorrhage
DUE TO (c): Hypertension Vascular Disease Due To

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 dy / 2 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that (I) ~~(XXXXXXXX)~~ attended the deceased from 5/10, 1960 to June 12, 1961, that (I) ~~saw~~ last saw the deceased alive on June 12, 1961, and that death occured at 2:23 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Theodore H. Johnson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 6/13/61

22c. PHYSICIAN'S NAME (Type): Theodore H, Johnson

22d. ADDRESS: 37 Calvert St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-15-61

23c. NAME OF CEMETERY OR CREMATORY: PineLawn

23d. LOCATION (City, town or county) (State): Annapolis Md

24 FUNERAL DIRECTOR'S SIGNATURE: C. E. Hicks, III

ADDRESS: Annapolis, Md

25a. REC'D BY REGISTRAR DATE: JUN 16 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) ISM 9/60

1-

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6392 Reg. Dist. No. 06376

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mago Vista, Pasadena
c. LENGTH OF STAY IN Tb: Few minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Mago Vista Beach

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. Va. b. COUNTY: Wood
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Parkersburg
d. STREET ADDRESS: 1404 Crescent St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Edward — Last: Patterson

4. DATE OF DEATH: Month: June — Day: 20 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Jan. 29, 1935

9. AGE (In years last birthday): 26 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Amusement Operator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Parkersburg, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Aubra L. Patterson

14. MOTHER'S MAIDEN NAME: Josie M. Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 232-52-4456

17. INFORMANT: Mr. A. L. Patterson, same as 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Went swimming in the Magothy River and suddenly drowned

20c. TIME OF INJURY: Hour 5.30 a m p m. Month, Day, Year: 6/20/61 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Magothy River

20f. (City or town) MagoVista Beach (County) A.A. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 6/23/61

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D. — Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 6/23/61

22c. NAME OF CEMETERY OR CREMATORY: Wilding

22d. LOCATION (City, town, or county) (State): Jackson Co. W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: William J. Lucente — ADDRESS: Lucente Bros. Balto 17 Md. / Balto 17, Md.

24a. REC'D BY REGISTRAR DATE: JUN 26 '61

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1 - 11 in 3290 7/3/61 iwk

CERTIFICATE OF DEATH

C393

Reg. Dist. No. 06377

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freetown, Glenburnie
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 323 Rt 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XGLENBURNIE -Freetown
d. STREET ADDRESS Box 323 Rt 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Charles Middle Asbury Last Pearmon
4. DATE OF DEATH Month 6 Day 25 Year 1961

5. SEX M
6. COLOR OR RACE N
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 25, 1883
9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months 7 Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME WILLIAM PEARMON
14. MOTHER'S MAIDEN NAME SARAH TAYLOR ~~Hayes~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (WIFE) LILLIE PEARMON Address (SAME)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH 1 week

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Cardio-vascular disease — 3 years.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic, generalized, hypertrophic osteoarthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 3, 1950 to June 25, 1961 that I last saw the deceased alive on June 24, 1961, and that death occurred at 12:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE R. M. McLaughlin M.D. ADDRESS (Street, city or town, state) 3108 Mountain Rd. Pasadena, Md. 6/25/61 DATE SIGNED

PHYSICIAN'S NAME (Type) R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 6/26/61
22c. NAME OF CEMETERY OR CREMATORY Hall's Memorial
22d. LOCATION (City, town, or county) (State) Marley Neck Glen Burnie

23. FUNERAL DIRECTOR'S SIGNATURE Sarah L. Brown ADDRESS 104 W Montgomery St

24a. REC'D BY REGISTRAR DATE JUN 29 '61
24b. REGISTRAR'S SIGNATURE Clarence E. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6394

CERTIFICATE OF DEATH

06378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b: 3 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Annapolis
   d. STREET ADDRESS: Rt-2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Osma — Middle: M. — Last: PENNINGTON

4. DATE OF DEATH: Month: June — Day: 11 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 29, 1902

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Adalbert Pennington

14. MOTHER'S MAIDEN NAME: Willie Bird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Samantha P. Pennington (2) — Address:

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO (b): Peritonitis — 24 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Intestinal obstruction (volvulus) — 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Porphyria

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~[illegible]~~ attended the deceased from June 8, 1961, to June 11, 1961, that (I) (~~[illegible]~~) last saw the deceased alive on June 11, 1961, and that death occured at 7:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Richard I. Hochman M.D

22b. DATE SIGNED: 6/12/61

22c. PHYSICIAN'S NAME (Type): Richard I. Hochman

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 100 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 14-1961

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City, town or county): Arnold (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.

25a. REC'D BY REGISTRAR DATE: JUN 19 '61

25b. REGISTRAR'S SIGNATURE: Evelyn L. Krause

17

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6395 — 06379

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
MARYLAND
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route I - Box 167

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Kirkland — b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Indianapolis
d. STREET ADDRESS: 2908 - S. Vale Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DARIS - Middle: DWYNN - ALVIN - Last: PERKINSON

4. DATE OF DEATH: Month: JUNE - Day: 29th - Year: 1961

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/29/10

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SET-UP-MAN-AT-MOULDING-CORP.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Anderson, Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Perkinson

14. MOTHER'S MAIDEN NAME: Margaret McDaris (Hardin)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give war or dates of service): Ward War II

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Irene Ida Perkinson (wife)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY - OCCLUSION.

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

6/29/61 DATE SIGNED

EXAMINER'S NAME (Type): GUSTAVE H. FAUBERT - M.D. Address (Street, city, town or county): Glen Burnie Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 3, 1961

22c. NAME OF CEMETERY OR CREMATORY: Indianapolis Natl Cemetery

22d. LOCATION (City, town, or country) (State): Indianapolis Indiana

23. FUNERAL DIRECTOR: DeWitt Arnoldson, Laurel, Md.

ADDRESS

24a. REC'D BY REG'STRAR DATE JUL 5 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO PHYSICIAN MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6396 — 06380

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: MARYLAND — 7 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL - Severn
d. STREET ADDRESS: 1 Donald Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First — Middle — Last: PIERCE

4. DATE OF DEATH: Month: June — Day: 10 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 10, 1961

9. AGE (In years last birthday) IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours: 6 — Min.: 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Albert Pierce

14. MOTHER'S MAIDEN NAME: Yvonne Celeste Phelps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): 7116X — Prematurity
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. I certify that (I) ~~(XXXXXXXX)~~ attended the deceased from June 10, 1961 to June 10, 1961, that (I) (We) last saw the deceased alive on June 10, 1961, and that death occured at 10:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Stuart M. Walker M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Stuart M. Walker

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 14-61

23c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cemetery

23d. LOCATION (City, town or county) (State): Rockville Pike Brookeville Md

24 FUNERAL DIRECTOR'S SIGNATURE: Bernard A Funk — ADDRESS: Glen Burnie Md

25a. REC'D BY REGISTRAR DATE: JUN 19 '61

25b. REGISTRAR'S SIGNATURE: Charles L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6397 **CERTIFICATE OF DEATH** 06381

Item 23 Film C288 6/19/61 mh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 **PLACE OF DEATH**
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore,
d. STREET ADDRESS: 1032 North Gilmore
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allen — Middle: — Last: Pollack

4. DATE OF DEATH: Month: 6 — Day: 9 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 26, 1931

9. AGE (In years last birthday): 29 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Pollack

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 1951 - 1953

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive Cardiovascular Disease

DUE TO (b): 443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I,e): Fatty Degeneration of liver Assoc. with Alcoholism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): ----------

20c. TIME OF INJURY: Hour a.m. p.m. ----- Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.): ------

20f. (City or town) (County) (State): ------

21. **I certify** that (I) (this hospital) attended the deceased from 3/13, 19 61 to 6/9, 19 61, that (I) (we) last saw the deceased alive on 6/9, 19 61, and that death occured at 12:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Lionel McHenry Mapp M.D.

22b. DATE SIGNED: 6/9/61

22c. PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 14, 1961

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis J. Kemsley

ADDRESS: 578 W. Baltimore St.

25a. REC'D BY REGISTRAR DATE: JUN 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6398 06382

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crain Hwy. (Rt. 3 Box 88)

2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d. STREET ADDRESS: Crain Hwy. (Rt. 3 Box 88)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: B. — Middle: Franklin. — Last: Pumphrey

4. DATE OF DEATH: Month: June — Day: 26 — Year: 1961

5. SEX: Male

16. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12th May 1883

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if not red): Policeman (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Balto. City Police

11. BIRTHPLACE (County & State, or foreign country): A. A. Co.) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B. Franklin, Pumphrey, Sr.

14. MOTHER'S MAIDEN NAME: Minnie Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service: No

16. SOCIAL SECURITY NO.: 216-16-2990

17. INFORMANT: Mrs. Ella E. Pumphrey — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1954 to June, 1961, that (I) (we) last saw the deceased alive on June 20 1961, and that death occured at 1:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: C.R. MacDonald M.D. — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/28/61

22c. PHYSICIAN'S NAME (Type): C.R. MacDonald,

22d. ADDRESS: Glen Burnie, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 30th June '61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.

23d. LOCATION (City, town or county) (State): BKlyn-RFD, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: R.Y. Singleton — ADDRESS: Glen Burnie, Md.

25a. REC'D BY REGISTRAR DATE: JUN 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 20 Film 289
6-23-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6399 — 06383

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, g ve street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 511 Ludlow Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sadie — Middle: — Last: ROSENSTEIN

4. DATE OF DEATH: Month: June — Day: 14 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 1, 1891

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: A. Kasakow

14. MOTHER'S MAIDEN NAME: ? Kasmacrsky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Hospital Records — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebrovascular Thrombosis	4 hrs
DUE TO (b)	Cerosis & hypertension	3 days
DUE TO (c)	Overdose of Dicumarol, accidental	2 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus; generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Patient took 3 dicumarol tablets daily instead of 1 2 digoxin (the digoxin bottle contained dicumerol - error has not been explained)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: June 19 61

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town) (County) (State): Annapolis Md.

21. I certify that (I) (~~XXXXXXXX~~) attended the deceased from June 11, 1961 to June 14, 1961, that (I) (~~XXe~~) last saw the deceased alive on June 14, 1961, and that death occured at 7:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John L. Hedeman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6/15/61

22c. PHYSICIAN'S NAME (Type): John L. Hedeman

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 16,1961

23c. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home

ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUN 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6400 — 06384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): RURAL - Arnold
d. STREET ADDRESS: Rt-3, Box-448
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Tressie — Middle: — Last: ROY
4. DATE OF DEATH: Month: June — Day: 13 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 9, 1920
9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: [illegible] NELSON
14. MOTHER'S MAIDEN NAME: [illegible] VAN METER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: GLEN ROY — Address: ABOUT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute pancreatitis
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 48hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town — (County) — (State)

21. **I certify** that (I) ~~[illegible]~~ attended the deceased from June 11, 1961 to June 13, 1961 that (I) (~~[illegible]~~) last saw the deceased alive on June 13, 1961, and that death occured at 7:22 A.M., from the causes and on the date stated above.

22a. SIGNATURE: S. Borssuck, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 6/13/61
22c. PHYSICIAN'S NAME (Type): Samuel Borssuck
22d. ADDRESS: Amos Garrett Blvd., Annapolis Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-16-61
23c. NAME OF CEMETERY OR CREMATORY: BALTO. NATIONAL
23d. LOCATION (City, town or county): BALTO. — (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]
25a. REC'D BY REGISTRAR DATE: JUN 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6405

CERTIFICATE OF DEATH

06389

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 200 King George St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: BELLAMY — Last: ST GEORGE

4. DATE OF DEATH: Month: June — Day: 18 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 29, 1896

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REAL ESTATE

10b. KIND OF BUSINESS OR INDUSTRY: BROKER

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM St GEORGE

14. MOTHER'S MAIDEN NAME: ISABELLE WESCOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.: I + II

17. INFORMANT: Ila R. St George (2) — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of lungs — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXXX~~) attended the deceased from 6-7-61, 1961, to June 17, 1961, that (I) (~~XX~~) last saw the deceased alive on June 17, 1961, and that death occured at 7:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank M. Shipley — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 6-20-61

22c. PHYSICIAN'S NAME (Type): FRANK M. SHIPLEY — 22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 6-21-1961 — 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial — 23d. LOCATION (City, town or county): Annapolis — (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: JUN 21 '61 — 25b. REGISTRAR'S SIGNATURE: Evelyn L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6401 — 06385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 825 Bay Ridge Ave.,
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James — Middle — Last: SARGEANT

4. **DATE OF DEATH**: Month: June — Day: 15 — Year: 1961

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: May 9, 1884 — 9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUTLER — 10b. KIND OF BUSINESS OR INDUSTRY: BUTLER — 11. BIRTHPLACE (County & State, or foreign country): England — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT (Address): Minnie S. Sargeant #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE CARDIO-VASCULAR DISEASE — 5 YRS.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) ~~XXXXXXXX~~ attended the deceased from June 11, 1961 to June 15, 1961 that (I) (~~XXX~~) last saw the deceased alive on June 14, 1961, and that death occured at 5:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Beck M.D. — 22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Edward S. Beck

22d. ADDRESS: 71 Franklin St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 6-17-61 — 23c. NAME OF CEMETERY OR CREMATORY: St. Marys — 23d. LOCATION (City, town or county) (State): Annapolis MD

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Son — ADDRESS: Annapolis, Md.

25a. REC'D BY REGISTRAR DATE: JUN 19 '61 — 25b. REGISTRAR'S SIGNATURE: Clifton B. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6402 06386

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN this place of death: 5 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: Prince Georges
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
   d. STREET ADDRESS: 7512 Blaine St., Comedy Hill
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Lawrence — Last: SEGER

4. DATE OF DEATH: Month: June — Day: 5 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 31, 1961

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days: 4 — IF UNDER 24 HRS.: Hours: 9 — Min.: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Edward Seger

14. MOTHER'S MAIDEN NAME: Dorothy Ellen Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records — Address:

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 7767 Pneumonia
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(did not)~~ attended the deceased from May 31, 1961, to June 5, 1961, that (I) ~~(did not)~~ last saw the deceased alive on June 5, 1961, and that death occured at 8:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — 22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): STUART M. WALKER M.D.

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: June 7, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery — 23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: A. Gasch's Sons Hyattsville Md.

25a. REC'D BY REGISTRAR DATE: JUN 8 '61 — 25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6403

CERTIFICATE OF DEATH

06387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Anne Arundel — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   c. LENGTH OF STAY IN Ib
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give stree. address): Anne Arundel General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if inst tution; Residence before admiss on)
   a. STATE: Maryland — b. COUNTY: Anne Arundel
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
   d. STREET ADDRESS: 10 Monticello Ave.
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First THOMAS — Middle JOHN — Last SLAFKOSKY

4. **DATE OF DEATH**: Month JUNE — Day 4 — Year 19 61

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Dec. 4, 1959 — 9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months 6, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none — 10b. KIND OF BUSINESS OR INDUSTRY: none — 11. BIRTHPLACE (County & State, or foreign country): Annapolis, Md. — 12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: A. Leonard Slafkosky — 14. MOTHER'S MAIDEN NAME: Margaret Mary Euff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no — 16. SOCIAL SECURITY NO.: no — 17. INFORMANT: none — Address: Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Aspiration Pneumonia with Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO (b): 753.1 Congenital Cardiac Defect

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a): 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from BIRTH, 19 .., to 6/4, 1961, that (I) (we) last saw the deceased alive on 6/4 19 61, and that death occured at 4 M, from the causes and on the date stated above.

22a. SIGNATURE: Philip Briscoe M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 6/4/61

22c. PHYSICIAN'S NAME (Type): Philip Briscoe — 22d. ADDRESS: Cathedral Street, Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: June 6, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — 23d. LOCATION (City, town or county) (State): Annapolis, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hopping Funeral Home, Annapolis, Maryland — 25a. REC'D BY REGISTRAR DATE: JUN 8 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6404 — 06388

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Pasadena
d. STREET ADDRESS: Rt-6, Box-160
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: S. — Last: SPRINKEL

4. DATE OF DEATH: Month: June — Day: 22 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 6, 1909

9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewerage plant

10b. KIND OF BUSINESS OR INDUSTRY: Balto. City,

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Samuel S. Sprinkel

14. MOTHER'S MAIDEN NAME: Mattie E. Bond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): yes — WWII

16. SOCIAL SECURITY NO.: 216-10-7509

17. INFORMANT — Address: Nona B. Sprinkel Rt. 6 Pasadena, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Massive pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 96 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b): Myocardial infarction due to

420.1 — DUE TO (c): Coronary thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lobar pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (~~XXXXXXXX~~) attended the deceased from June 17, 1961, to June 22, 1961 that (I) (~~XXX~~) last saw the deceased alive on June 22, 1961, and that death occured at 7:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Arthur Lankford Jr. M.D.

22b. DATE SIGNED: 6/22/61

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Arthur Lankford, Jr.

22d. ADDRESS: 2934 Mountain Road, Pasadena, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 6/26/61 — 23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem. — 23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Howard H. Hubbard — ADDRESS: 4107 Wilkens Ave.

25a. REC'D BY REGISTRAR DATE: JUN 26 '61 — 25b. REGISTRAR'S SIGNATURE: Curtis L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6406 — 06390

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH** — a. COUNTY: Anne Arundel — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — c. LENGTH OF STAY IN this place: 1 year, 7 months, 3 days — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Crownsville State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: Md — b. COUNTY: Anne Arundel — CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eastport — d. STREET ADDRESS: 610 2nd Street — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ELIZABETH — Middle: — Last: TAYLOR

4. **DATE OF DEATH**: Month: 6 — Day: 3 — Year: 1961

5. SEX: F

6. COLOR OR RACE: N

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/25/1928

9. AGE (In years last Birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN

10b. KIND OF BUSINESS OR INDUSTRY: UNKNOWN

11. BIRTHPLACE (County & State, or foreign country): USA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOE B. TAYLOR

14. MOTHER'S MAIDEN NAME: CATHERINE GRACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): no

16. SOC. A. SECURITY NO: no

17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia with

DUE TO (b): Pulmonary Infarctions of unknown

DUE TO (c): origin

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): Mental Deficiency

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part II or Part I of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/28 19 59 to 6/3 19 61, that (I) (we) last saw the deceased alive on 6/3 19 61, and that death occured at 2:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Carl B. Schleifer

22b. DATE SIGNED: June 4, 1961

22c. PHYSICIAN'S NAME (Type): Carl B. Schleifer, M. D.

M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22d. ADDRESS: Crownsville State Hospital, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 7 1961

23c. NAME OF CEMETERY OR CREMATORY: BREWER HILL

23d. LOCATION (City, town or county) (State): ANNAPOLIS, A.A. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: James H. Johnson

ADDRESS: Pleasant St. ANNAPOLIS MD

25a. REC'D BY REGISTRAR — DATE: JUN 12 '61

25b. REGISTRAR'S SIGNATURE: Carlton L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

0407 **CERTIFICATE OF DEATH** 06391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL – Annapolis
d. STREET ADDRESS: Pendennis Mount
a. IS RES. ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: M. — Last: THOMAS

4. DATE OF DEATH: Month: June — Day: 18 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 29, 1878

9. AGE (In years last birthday): 83 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LUMBER BUISNESS

10b. KIND OF BUSINESS OR INDUSTRY: LUMBER-HARDWARE

11. BIRTHPLACE (County & State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN M. THOMAS

14. MOTHER'S MAIDEN NAME: EMMA KENDRICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO: –

17. INFORMANT: NANCY B. THOMAS — Address: (2)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks +

DUE TO (b): Cerebro-Vascular Hemorrhage — 9 wks +

DUE TO (c): Arteriosclerosis, Generalized — 1 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(XXXXXXXXX)~~ attended the deceased from 5-13- 1961 to 6-18- 1961, that (I) (~~we~~) last saw the deceased alive on 6-18- 1961, and that death occured at 7:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James R. Martin — M.D. — ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-19-61

22c. PHYSICIAN'S NAME (Type): James R. Martin

22d. ADDRESS: 6 Shaw St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/20/1961

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemt

23d. LOCATION (City, town or county): Washington (State) D C

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Saylor Sons — ADDRESS: Annapolis Md

25a. REC'D BY REGISTRAR DATE: JUN 21 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G288 6/12/61 iwk

6408

CERTIFICATE OF DEATH

Reg. Dist. No. 06392

1. PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - Rt 2
c. LENGTH OF STAY IN 1b: 20 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MILLERSVILLE - Box 35

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL X
d. STREET ADDRESS: MILLERSVILLE - Box 35
e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print): First Richard — Middle Wesley — Last Tongue Sr.

4. DATE OF DEATH: Month 6 — Day 2 — Year 1961

5. SEX: M.

6. COLOR OR RACE: C

7. MARRIED X — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 4-10-1899

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): State Of Md. Roads Comm.

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (State or foreign country): A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eli Tongue

14. MOTHER'S MAIDEN NAME: Martha Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217-16-3470

17. INFORMANT: Alverta A. Tongue — Address: Box 35 Rt 2 Millersville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Cerebral Vascular Accident — 26 months
DUE TO (c): H.S.C.V.D. —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1961 to May 4, 1961, that I last saw the deceased alive on 6-1-61, 19, and that death occurred at 2 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D.: Felix Fenus — ADDRESS (Street, city or town, state): 609 Odenton Rd Odenton Md — DATE SIGNED: 6/3/61

PHYSICIAN'S NAME (Type): Felix Fenus

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6-5-61

22c. NAME OF CEMETERY OR CREMATORY: Chews Chapel

22d. LOCATION (City, town, or county) (State): A.A. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C.E. Hicks III — ADDRESS: Annapolis - Md.

24a. REC'D BY REGISTRAR DATE: JUN 7 '61

24b. REGISTRAR'S SIGNATURE: Curtis L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6409

Reg. Dist. No. 06393

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
c. LENGTH OF STAY IN 1b: 9 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
d. STREET ADDRESS: Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First LUGINA Middle Last WHITENER

4. DATE OF DEATH: Month JUNE Day 1 Year 1961

5. SEX: F

6. COLOR OR RACE: C

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8 DATE OF BIRTH: 12-17-1880

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): South Carolina

12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Pete Hudson

14 MOTHER'S MAIDEN NAME: Matilda GLENN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)

16 SOCIAL SECURITY NO:

17 INFORMANT: Gertrude Harris Address: Ridge Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 30 Hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from winter, 1959, to 5-31, 1961, that I last saw the deceased alive on 5-31, 1961, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jose M. Yosuico M.D. M.D.
ADDRESS (Street, city or town, state): Jessup, Md.
DATE SIGNED: 6-1-61

PHYSICIAN'S NAME (Type): Jose M. Yosuico, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/6/1961
22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
22d. LOCATION (City, town, or county) (State): Elkridge Md

23 FUNERAL DIRECTOR'S SIGNATURE: Mrs Katie R Williams
ADDRESS: 322 N Schroeder St

24a REC'D BY REGISTRAR
DATE JUN 5 '61

24b REGISTRAR'S SIGNATURE: Lindsay R Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

Item 18 Film 292 8-2-61 ars

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6411 — 06395

FOR STATE HEALTH DEPT. — 1

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 30 y.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): District Training School, Pine Cottage,

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 330 K Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Russell — Middle Windlund — Last
4. DATE OF DEATH: Month June — Day 29th — Year 1961

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/6/24
9. AGE (In years last birthday): 37 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Children's Center Records. Laurel.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Status Epilepticus — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): 353,2 — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. City or town — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Charles S. Petty, M.D.
Address (Street, city, town, or county):
6/30/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/30/61
22c. NAME OF CEMETERY OR CREMATORY: District Training School
22d. LOCATION (City, town, or country): Laurel — (State): Maryland

23. FUNERAL DIRECTOR: John J Mooney Jr. DTS Laurel Md — ADDRESS
24a. REC'D BY REGISTRAR — DATE: JUL 7 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Kinnie

IMPORTANT MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6410 — 06394

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: 20 y.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 294 Magothy Beach Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter — Middle Lee — Last Woods
4. DATE OF DEATH: Month June — Day 23rd. — Year 1961

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/15/08
9. AGE (In years last birthday): 52 Yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Howard Woods, (son) 247 Hanover St. Annapolis, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary-Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 6/23/61

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.
Address (Street, city, town or county): Glen Burnie, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-27-61
22c. NAME OF CEMETERY OR CREMATORY: Magothy Area
22d. LOCATION (City, town, or country) (State): Anne Arundle Co.

23. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brooklyn Ave.

24a. REC'D BY REGISTRAR DATE: JUL 10 '61
24b. REGISTRAR'S SIGNATURE: Arthur B Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

6412 — Reg. Dist. No. 06396

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Geo G Meade,
c. LENGTH OF STAY IN 1b: 19 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: US ARMY Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3305 Round Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOYCE — Middle L — Last YOUNG
4. DATE OF DEATH: Month JUNE — Day 18 — Year 19 61

5. SEX: Female
6. COLOR OR RACE: Negroid
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7 Jan 1959
9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Detroit, Mich
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: GERALD F YOUNG
14. MOTHER'S MAIDEN NAME: Elizabeth Bowman (Mother) 3305 Round Rd Baltimore, Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: (Mother) Elizabeth Bowman 3305 Round Rd — Address: Baltimore, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Rt Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 19 Days

754.4

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Congenital Heart Disease (Cyanotic) — 28 Months

DUE TO

(c) Subendocardial fibroelastosis (Suspected)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Respiratory Infection

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 17 June, 19 61, to 18 June, 19 61, that I last saw the deceased alive on 18 June, 19 61, and that death occurred at 0314 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Clift M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type) JOHN CLIFT MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/21/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nation
22d. LOCATION (City, town, or county) (State): Arlington Va

23. FUNERAL DIRECTOR'S SIGNATURE: Enoch J Arnold Jr — ADDRESS: 10 W Montgomery

24a. REC'D BY REGISTRAR DATE: JUN 21 '61
24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6413

CERTIFICATE OF DEATH

06397

Items 9 & 11 Film 0288 6/9/61 mh

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 6 Goodrich Road, Admiral Heights
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: JOSEPH — Last: ZACHARIAS

4. DATE OF DEATH: Month: June — Day: 5 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 20, 1910

9. AGE (In years last birthday): 51 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINT. SUPERVISOR

10b. KIND OF BUSINESS OR INDUSTRY: U. S. GOVERNMENT

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: OTTO ZACHARIAS

14. MOTHER'S MAIDEN NAME: ---------- Hoffbecker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give wer or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: VELMA P. ZACHARIAS — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peripheral circulatory collapse. — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.
DUE TO
322.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Delirium Tremens. — 3 days.
DUE TO
(c): Alcoholism — Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~XXXXXXXXXX~~) attended the deceased from June 2nd, 1961, to June 4, 1961, that (I) (~~XXX~~) last saw the deceased alive on June 4, 1961, and that death occured at 2:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Gerard Church M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Gerard Church

22d. ADDRESS: 121 Cathedral St., Annapolis, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 6-7-61
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial
23d. LOCATION (City, town or county) (State): Annapolis Md

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis MD

25a. REC'D BY REGISTRAR / DATE: JUN 7 '61
25b. REGISTRAR'S SIGNATURE: Cathryn S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after ... Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60